

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS647HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2009
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as the result of a complaint investigation survey conducted at your facility on 03/05/09 and 03/06/09.</p> <p>The state licensure survey was conducted in accordance with Chapter 449, Hospitals, adopted by the State Board of Health December 11, 1998 last amended September 27, 1999.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The following 18 complaints were investigated.</p> <p>Complaint # 19685 - Unsubstantiated Complaint # 19930 - Unsubstantiated Complaint # 20980 - Unsubstantiated Complaint # 19801 - Unsubstantiated Complaint # 19906 - Unsubstantiated Complaint # 20804 - Unsubstantiated Complaint # 21036 - Unsubstantiated Complaint # 21050 - Unsubstantiated Complaint # 19476 - Unsubstantiated Complaint # 21168 - Unsubstantiated Complaint # 16483 - Unsubstantiated Complaint # 19497 - Substantiated (Tag S0322) Complaint # 20999 - Substantiated (Tag S0310) Complaint # 21056 - Substantiated (Tag S0115) Complaint # 20325 - Substantiated without deficiencies Complaint # 20653 - Substantiated (Tag S0146) Complaint # 20961 - Substantiated without deficiencies Complaint # 16263 - Substantiated without</p>	S 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS647HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2009
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Continued From page 1 deficiencies The following regulatory deficiencies were identified.	S 000		
S 115 SS=C	NAC 449.325 Infections and Communicable Diseases 1. A hospital shall: (a) Provide a sanitary environment to avoid sources and transmission of infections and communicable diseases This Regulation is not met as evidenced by: Based on observation and document review, the facility failed to provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. Findings include: Observation on the 200 and 300 wing from 11:30 am through 12:30 PM of the staff identified the following: 1. Two nurses were observed getting medications out of the Pyxis. Neither nurse was observed to have used a hand sanitizer. 2. Multiple staff was noted entering and leaving residents rooms, there was no observation of staff using hand sanitizer or wearing of gloves. The Hand Hygiene and skin antisepsis policy dated 1/2003 and revised on 4/2205 documented the indications for use of hand hygiene were: upon entering and leaving patient's hospital room, between patient contact, before and after performing procedures, before medication preparation, before donning and after removing gloves, after touching inanimate objects that are	S 115		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS647HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2009
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 115	Continued From page 2 likely to be contaminated with pathogenic microorganisms and when hands are soiled. Hand washing was indicated when hands were visibly dirty. Severity: 1 Scope: 3 Complaint #NV00021056	S 115			
S 146 SS=D	NAC 449.332 Discharge Planning 4. An evaluation of the needs of a patient relating to discharge planning must include, without limitation, consideration of: (a) The needs of the patient for postoperative services and the availability of those services; (b) The capacity of the patient for self-care; and (c) The possibility of returning the patient to a previous care setting or making another appropriate placement of the patient after discharge. This Regulation is not met as evidenced by: Based on record review the facility failed to ensure the discharge placement of a patient was appropriate. (Patient #3) Findings include: Patient #3 was a 82 year old female who was admitted to the facility on 11/27/08, post spinal surgery for rehabilitation and further treatment. A Physicians discharge Summary dated 01/06/09 indicated Patient #3 was sent to an Assisted Living Facility with a Methicillin Resistant Staphylococcus aureus bloodstream infection and a Peripherally Inserted Central Catheter. A Physician Progress Note dated 1/6/09, indicated the plan was to discharge Patient #3	S 146			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS647HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2009
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 146	Continued From page 3 back to an Assisted Living Facility and to continue Vancomycin intravenously for 4 more weeks. The order read as follows: "Patient can be discharged to ... assisted living, do not discontinue Peripherally Inserted Central Catheter. Home health nurse to administer IV antibiotic, Vancomycin 1 gm (gram) every 24 hr x 4 weeks." Social Service Note dated 01/07/09 indicated Patient #3 was discharged to an Assisted Living facility. Severity: 2 Scope: 1 Complaint #NV00020653	S 146		
S 310 SS=D	NAC 449.3624 Assessment of Patient 1. To provide a patient with the appropriate care at the time that the care is needed, the needs of the patient must be assessed continually by qualified hospital personnel throughout the patient's contact with the hospital. The assessment must be comprehensive and accurate as related to the condition of the patient. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to provide a patient with the appropriate care at the time the care was needed and failed to notify the physician to have the patient reassessed when there was a significant change in the patients condition. (Patient # 10) Findings include: Patient #10 was a 79 year old female admitted to the facility on 02/04/09 for rehabilitation following a recent left total hip arthroplasty. The patients	S 310		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS647HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2009
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 310	<p>Continued From page 4</p> <p>diagnoses included postoperative anemia, degenerative joint disease, hypothyroidism, hypertension and gastroesophageal reflux disease.</p> <p>A Physicians Progress Note dated 02/05/09, indicated the patient was evaluated after she felt her hip was dislocated last night after the nurse folded her leg. The physician indicated he was not notified of the incident until 02/05/09 at 4:00 PM.</p> <p>A Physicians History and Physical dated 02/06/09, indicated the patient was a 79 year old female with a history of degenerative joint disease. "The patient was seen by a nurse and apparently the left hip folded over and the patient thought she displaced her left hip and complained of pain. An X-ray of the left hip was done and reviewed. There was no dislocation or misalignment of the hardware of the left hip joint."</p> <p>On 03/06/09 at 9:30 AM, Employee #1 indicated the patient and her son spoke with him on 02/06/09 regarding a complaint concerning a possible injury to the patients left hip when being transferred by a nurse. The patient complained that her physician was not notified about the incident by the nurse which caused a delay in her condition being re-assessed by a physician and an x-ray of her left hip obtained to rule out a dislocation. Employee #1 indicated he filled out a patient incident and accident investigation report per facility policy. Employee #1 confirmed the patients nurse failed to report the incident to the charge nurse or physician and failed to document the incident in the nurses progress notes. The nurse failed to complete a patient injury/accident report per facility policy.</p>	S 310			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS647HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2009
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 310	<p>Continued From page 5</p> <p>A facility Patient Incident Accident Investigation Worksheet dated 02/06/09, and completed by Employee #1 indicated the patient stated a staff member who was assisting the patient with a transfer did not transfer her properly causing pain to the patient's surgical site during and after the transfer. The patient and son complained about a delay in the patient receiving an examination by a physician and a hip x-ray after experiencing pain following the transfer. The patient and son wanted the patient transferred to another rehabilitation facility.</p> <p>On 03/06/09 at 11:00 AM a telephonic interview was conducted with the Complainant. The Complainant indicated on 02/04/09 at 11:30 PM, the patients left hip was injured while a nurse was attempting to transfer or place the patient on a bed pan. The patient had recent left hip surgery and immediately complained of pain in her left hip. The patient asked the nurse for a doctor that evening to evaluate her hip and get an x-ray to make sure her hip was not dislocated. The patient made numerous requests to see a physician and have an x-ray of her hip to rule out a dislocation. No physician saw the patient and no x-ray was taken of her left hip until 02/05/09 at 5:30 PM.</p> <p>On 03/06/09 at 1:20 PM, a telephonic interview was conducted with Employee #2 who confirmed he was Patient #10's nurse on 02/04/09 during the night shift. Employee #2 indicated on 02/04/09 at approximately 11:30 PM, the patient asked to use the bed pan. Employee #2 indicated while attempting to place the patient on a bed pan he lifted her left leg slightly off the bed. The patient who had recent left hip surgery screamed and immediately complained of pain to her left hip. The patient denied the need for pain</p>	S 310			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS647HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2009
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 310	<p>Continued From page 6</p> <p>medication at that time. Employee # 2 indicated the patient complained of left hip pain later in the shift and he medicated the patient with Percocet 1 tablet by mouth at 4:00 AM. Employee #2 reported the patient never asked to see a physician and never asked for a hip x-ray. Employee #2 acknowledged he never reported the incident to the charge nurse or called the physician regarding the incident.</p> <p>Employee #2's Nursing Notes dated 02/04/09 indicated the following:</p> <ol style="list-style-type: none"> 1. 11:30 PM, "Patient received in bed alert and responsive." "No complaints of pain." 2. 1:00 AM, " PM meds given and taken, no side effects noted." 3. 3:00 AM, "Status check every 2 hours completed." 4. 5:00 AM, "Status check every 2 hours completed." 5. 7:00 AM, "Status check every 2 hours completed." <p>The patients Pain Management Assessment form dated 02/04/09 had no entries that documented the times of pain medication administration or the description and intensity of the patients pain.</p> <p>Medication Administration record dated 02/04/09 at 4:40 AM, indicated the patient was medicated for pain with Percocet 1 tab by mouth by Employee #2.</p> <p>A Portable x-ray report dated 02/05/09 at 5:29 PM, indicated a left hip x-ray was taken for pain in the pelvis, left hip and upper thigh. There was no fracture or acute dislocation of the patients left hip. The patients physician was notified of the x-ray results on 02/05/09 at 10:20 PM.</p>	S 310		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS647HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2009
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 310	Continued From page 7 The facility Incident Reporting Policy dated 2003, indicated the staff will record any unusual situation or injury of a patient, staff member or visitor in accordance with applicable state and federal law and regulations. Documentation will include: 1. Notification of family and physician. 2. Patient status follow-up. 3. Refer to Administrative Structure Standards. 4. Refer to other state specific regulations. Severity: 2 Scope: 1 Complaint #NV00020999	S 310			
S 322 SS=D	NAC 449.3628 Protection of Patients 2. The governing body shall develop and carry out policies and procedures that prevent and prohibit neglect and misappropriation of the personal property of a patient. This Regulation is not met as evidenced by: Based on interview and document review the facility failed to carry out policies and procedures that prevent and prohibit the loss of personal property of a patient. (Patient # 7) Findings include: Patient #7 was an 86 year old female admitted to the facility on 10/12/08 with diagnoses that included cirrhosis of the liver, ascites and anemia. A large bag of medications belonging to the patient was missing upon discharge from the facility.	S 322			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS647HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2009
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 322	<p>Continued From page 8</p> <p>On 03/05/09 at 4:20 PM, Employee #1 reported the facility's personal effects property policy indicated that medication brought into the facility by a patient are locked up and returned to the patient upon discharge or transfer from the facility. Employee #1 indicated an Inventory of Personal Effects form was filled out by the nurses documenting the patient's property upon admission and what property was given to the patient or family member upon discharge. The nurse and the patient were responsible for signing the form upon admission and discharge. Employee #1 confirmed there was no documentation of a Personal Effects List completed by the nurses located in Patient #7's medical record. Employee #1 confirmed there was no documentation in the medical record that indicated the patients property (medication) was returned to the patient upon discharge.</p> <p>The facility's Admitting a Patient Policy dated 03/06, indicated the licensed nurse was responsible for interviewing the patient on admission to the facility and completing the personal effects list. Any medications the patient has with him/her were given to the charge nurse.</p> <p>A sample Inventory of Personal Effects form indicated under instructions: "Upon admission, identify the resident's personal belongings by indicating quantity of those items listed. The original copy shall be kept in the resident's chart. The copy is given to the resident or resident representative. Upon discharge use the check columns to indicate that all personal belongings are accounted for."</p> <p>Severity: 2 Scope: 1</p>	S 322			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS647HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2009
NAME OF PROVIDER OR SUPPLIER HARMON MEDICAL AND REHABILITATION HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2170 EAST HARMON AVENUE LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 322	Continued From page 9 Complaint #NV00019497	S 322			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.